Authorization Granting Access to MyChart Medical Record

You are granting your parent/guardian Proxy access to your MyChart medical record. A person who is granted access to another individual's medical record is called a "Caregiver" or "Proxy." In order to establish a Proxy, both the Proxy and the patient must sign this form.

If you sign this form, you are agreeing that your Parent(s) or Guardian(s) can look at your electronic health information. You will also be given access to your MyChart account.

This form must be completed by the patient, parent/guardian, and physician during the office visit.

I understand there is an electronic medical record with information about my medical care and treatment at Hackensack Meridian Health, and from doctors who work with the hospital. I am aware that some of my medical information from this record can be looked at through a secure website called Hackensack Meridian MyChart.

- I want to give my parent(s) or guardian(s) permission to use MyChart to look at my medical information, including information about my *past, current* and *future* care and treatment at Hackensack Meridian Health and affiliated facilities, doctors and offices.
- I understand that this permission form may allow my parent(s)/guardian(s) to see all of my health care information that is on MyChart, including information related to **PREGNANCY or BIRTH CONTROL, SEXUAL TRANSMITTED DISEASE (STD) TREATMENT** (and other **REPRODUCTIVE HEALTH CARE**), **ALCOHOL or DRUG ABUSE TREATMENT, GENETIC TESTING, MENTAL HEALTH CARE** and/or **HIV or AIDS** (HIV is short for Human Immunodeficiency Virus, the virus that causes AIDS). I understand that after my parent/guardian reviews my medical information, it could be disclosed to others and would no longer be protected by federal privacy regulations.
- I understand that MyChart allows for confidential messaging. I can choose to send messages to my doctors and select the option that prohibits my parents(s)/guardian(s) from having the ability to view the messages.
- I know that I do not have to sign this form or use MyChart, and I can still get treatment from Hackensack Meridian Health and their doctors.
- I understand that this permission form will not expire unless I request to have this access revoked through my MyChart account. I understand that Hackensack Meridian Health and my doctors can revoke access to MyChart (for patients or their Proxies) at any time and for any reason.
- I had a chance to ask questions about this permission form. Any questions I had were answered. If I choose to give my permission now, I can change my mind and cancel this permission form later at any time.

Please remember to read and complete page (2) of this form.

Please note that this form **should not** be used in the case of an emancipated minor.[1] An emancipated minor should use the Adult Proxy Form. To request a paper copy of your child's record, contact the Health Information Department at Hackensack Meridian Health (listed on page 2). Below are the following age range limitations for MyChart.

- If your child is age 0-11, you will be granted full access to your child's MyChart record.
- If your child is age 12-17, you will be granted partial access to your child's MyChart record (e.g., immunizations and allergies) automatically. When a teen Proxy consent form is completed and processed by your teen's doctor, you will be granted full access.
- Once your child reaches age 18, you will no longer have access to your child's MyChart record.

[1] In New Jersey, an "emancipated" minor is a person under the age of 18 who is: (a) is married, (b) pregnant, (c) in U.S. military service, or (d) declared emancipated by a court or administrative agency.

Make sure you have read the information provided on page (1) before signing this form.

➢ **PATIENT Information:** (All sections required — please print clearly)

Name (*last, first, middle initial*): ______________________ Date of Birth: ______________

Street Address: ______________ City: ______________ State: ________ Zip: ________

Home Phone Number: ______________

➢ **Parent(s)/Guardian(s) Information: [Who will be given access to your MyChart]**

Name (*last, first, middle initial*): ______________________ Date of Birth: ______________

Street Address: ______________ City: ______________ State: ________ Zip: ________

Email Address: ______________ Home Phone Number: ______________

➢ **Reason for Release of Information:** Parent(s)/Guardian(s) Access to MyChart

Information may include: *Pregnancy, STD Treatment, Reproductive Health Care, Alcohol/Drug Abuse Treatment, Genetic Testing, Mental Health or HIV-related information.*

By signing this form, I agree that the individual I have listed above can have access to my medical information in MyChart.

MyChart Terms and Agreement

- I understand that MyChart is intended to provide limited access to confidential medical information. If I share or allow my MyChart ID and password to be disclosed to another person, that person may be able to view my health information, and information about someone who has authorized me as a MyChart Proxy and transmit that information to a third party.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that MyChart contains selected, limited medical information from a patient's medical record and that MyChart does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the HMH Health Information Department at:

Hackensack University Medical Center at 551-996-2074	Jersey Shore University Medical Center at 732 776-4771
Bayshore Medical Center at 732 739-5985	Ocean Medical Center at 732 840-3331
Riverview Medical Center at 732 660-2510	Southern Ocean Medical Center at 609-978-3820
Raritan Bay Medical Center, Perth Amboy at 732 324-5391	Raritan Bay Medical Center, Old Bridge at 732 360-4237
Palisades Medical Center, at 201-854-5081	JFK Medical Center 732-321-7177

- I understand that access to MyChart is provided by Hackensack Meridian Health as a convenience to its patients and that Hackensack Meridian Health has the right to deactivate access to MyChart at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart Proxy.
- I understand that while Hackensack Meridian Health will use reasonable security efforts, no system can guard against all risks of intentional intrusion or inadvertent disclosure of medical information on MyChart. MyChart transmits medical information over the internet, a medium that is beyond the control of Hackensack Meridian Health and its contractors. I HEREBY EXPRESSLY ASSUME THE SOLE RISK OF ANY UNAUTHORIZED DISCLOSURE OR INTENTIONAL INTRUSION, OR OF ANY DELAY, FAILURE, INTERRUPTION OR CORRUPTION OF DATA OR OTHER INFORMATION TRANSMITTED IN CONNECTION WITH THE USE OF THIS SERVICE.
- I understand that this form authorizes Hackensack Meridian Health to provide my medical information, which may include *Pregnancy, STD Treatment, Reproductive Health Care, Alcohol/Drug Abuse Treatment, Genetic Testing, Mental Health or HIV-related information*, via MyChart to the designated Proxy listed above.
- MyChart allows patients and Proxies the ability to use confidential messaging. You can elect to message a physician and prevent others from viewing the correspondence.
- You should not make any decision relating to your health based upon the information available in MyChart and/or in your medical record. You always should consult with your physician for health-related matters.
- **I have read, understand and agree to the terms and conditions set forth on this page, as well as the terms and conditions included on the webpage used to access MyChart – HMHMyChart.**

▶ ____

Signature of Patient (required) **Date *(required)***

▶ ____

Signature of Parent/Guardian (required) **Date *(required)***

FOR OFFICE USE ONLY – Name of Provider who validated Proxy Access (please print)

Physician: ______________ **Department:** ______________ **Date:** ________